

# WINDHORSE THERAPY: CREATING WHOLE PERSON RECOVERY ENVIRONMENTS

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The Windhorse Therapy process is a multilayered and comprehensive treatment approach for people with a wide variety of mental health recovery needs. In this approach, *for every client we create an individually tailored therapy environment, addressing their needs in a whole person manner*. This approach also includes, whenever possible, the voice and needs of the client's family.

Windhorse Therapy is based on ancient understandings of the fundamental nature of human health and the energy it takes to recover from mental and life disturbances. With this as its foundation, it incorporates a combination of ordinary common sense, distinctive learnings gained from 27 years of clinical experience applying the Windhorse treatment process, and the application of appropriate psychological therapy or therapies. A key element of potency in this approach, both in its view and experience, is that no matter how severely confused a mind has become, recovery is possible.

The term "windhorse" refers to an energy that is naturally positive, confident, uplifted, and, according to the Buddhist tradition, fundamental to human beings. Our individual connection to this energy can wax and wane depending on what's happening in our environment and inside ourselves. And, windhorse energy can be deliberately roused and cultivated. When this energy is strong, we feel confident that our life is workable. *Windhorse* was chosen as the name of this type of therapy because it is the energy that is essential for people to discover in order to recover from mental illness and difficult life problems. (Trungpa, 1999)

## Historical Roots

The Windhorse Project, as it was originally called, arose out of the powerful environment of the early 1980's at Naropa Institute (now, Naropa University), and the atmosphere and teachings of Chogyam Trungpa. At that time, many outstanding and accomplished people had been drawn to him, and his influence invariably had the effect of helping experts to see their respective disciplines in a new light and larger context. Buddhist scholars, poets, dancers, musicians, and many involved with psychology found these experiences not just enlivening, but revolutionary in the way they now saw their activities. The late Dr. Edward Podvoll, who had had a distinguished career as director of psychiatry at the highly respected inpatient psychiatric hospital Chestnut Lodge, was one of these people. Through years of inpatient psychiatric work, Podvoll knew about the benefits and deficits of the inpatient environment. That knowledge, coupled with his developing contemplative perspective, showed him that there were other ways one could work with people in extreme mental states. In 1981, with the help of Trungpa and a group of committed students, Podvoll founded the Windhorse Project. (Podvoll, 2003)

Although the Windhorse approach was originally designed only for seriously disturbed individuals, we now treat people with a wide variety of mental health recovery needs, from those whose lives are minimally disrupted to those who need 24-hour per-day support. Teams range in size from two people, involving minimal expenses and perhaps meeting with the client only once per week, to teams with up to 20 people and round the clock contact. The length of a typical Windhorse Therapy ranges from six months to two years, but some last much longer. Many treatments are still conducted for people with acute and chronic mental disturbances: schizophrenia, schizoaffective disorder, bipolar and major depression. However, we find that Windhorse Therapy also effectively treats milder forms of mood disorders, substance abuse and addictions, eating disorders, autism, and head injuries, for example. Typically clients have difficult combinations of a number of these issues. Most clients are adults, age 18 and older, but it is not uncommon on the young end of the continuum for Windhorse Therapy to work with teenagers as young as 14 years old. At the older end, we work with people on issues of normal aging, dementia, and mental health. In this elder work, it is common to accompany someone and their family through the process of death.

A simple snapshot of a Windhorse Therapy looks like the following: a client lives in a house with a housemate who is part of a treatment team. Their relationship resembles that of ordinary housemates. There may be a number of clinicians on the team who spend time with the client on a regular basis, creating a schedule of generally one "shift" per day or more. Within that contact, a wide variety of activities takes place, from keeping the house in order to helping them get out and connect with their interests in the world. These activities are elements of an individually tailored environment to help the person live in an ordinary and healthy way, with good relationships and interesting activities. The client may work, see friends and family, and be part of the normal community in which they live. S/he may meet with a psychotherapist, usually once per week, and with a psychiatrist if they use medications. There is a system of meetings that all members of the team, including the client and their family, participate in. These keep the activity of the therapy, household, and treatment team coordinated, up-to-date, and in step with the evolving recovery needs.

### Therapeutic Foundations

Windhorse treatments are based on three healing principles. The first, which is the foundation, is that *all human beings are fundamentally sane and healthy*. As Trungpa states, "*Mental confusion exists and functions in a secondary position to that basic health.*" (page 160) Thus mental confusion functions at a much less essential level than the client and the client's family may believe. This first principle is not about just adopting an optimistic attitude toward human beings. Confidence in basic sanity is a direct experience that results from the clinician's exposure to contemplative discipline, which will be discussed later.

The second principle of the Windhorse Therapy process is, *because human beings are inseparable from their environments*, (Epstein, 1999) *if a healthy environment is created for the treatment, then clients will have a greater probability of recovery*. Stated by Trungpa: "The basic point is to evoke some gentleness, some kindness, some basic goodness, some contact. When we set-up an environment for people to be treated, it should be a wholesome environmental situation. A very

disturbed or withdrawn patient might not respond right away--it might take a long time. But if a general sense of loving kindness is communicated, then eventually there can be a cracking of the cast-iron quality of neurosis: it can be worked with." As we will see, creating tailored healing environments is the core therapeutic methodology of the Windhorse Therapy process.

The third principle of Windhorse Therapy is, *recovery is discovering and synchronizing with one's own fundamental health and sanity.* (Trungpa, 2005) As our clinical results show, the client gains health, skills for their particular life needs, confidence, and independence as this discovery and synchronization take place and stabilize. For Windhorse clinicians, recovery is characterized by a significant, stable, and heartening increase in the client's "windhorse" energy.

A thoroughly trained Windhorse clinician has a confident and practical understanding of all three of these core principles. Specifically, the Windhorse therapist must have (1) strong experience of their own basic sanity, and confidence in the basic sanity and health of others; (2) knowledge and experience of the view and practice of the Windhorse treatment process; and (3) therapeutic expertise for treating specific psychological disorders. There is a variety of standard ways that Windhorse professionals gain expert skill sets for treating specific mental disorders, but for the purposes of this discussion, we will focus solely on the elements of Windhorse Therapy that make this treatment process unique. For this, we will look at its foundation in contemplative discipline and at the methodology and practice of the Windhorse treatment process itself.

### Contemplative Roots

"Much of modern psychology seeks to know about others; too much of it in my opinion, without an equal commitment to knowing the self. But I believe that knowing the other-which is different from knowing about the other-can only be a function of knowing oneself. "

Bruno Bettelheim, *The Empty Fortress* (p.3)

Windhorse Therapy is a treatment process whose innovations are founded in the practice of a contemplative tradition. Whatever its form, contemplative discipline invites a progressively more intimate relationship with one's own mind and life in a fresh, moment-to-moment way. (Trungpa, 2005) Because this work is based on cultivating honest relationship and communication, from a basic training standpoint, deep familiarity with our own mind and experience actually allows the Windhorse Therapy process to begin and function. It is also important to note that a typical contemplative process follows the basic pattern of a typical process of mental health recovery. This parallel has great implications for the design of our tailored Windhorse environments, and for how a client's recovery process is defined, nurtured, and achieved. (Epstein, 1999)

Looking first at a typical contemplative process, it usually begins with the distinct sense that something is not right with the way life is going. "I'm not sure what to do, but if I don't change how I do things, I'll keep getting the same results, and that's no longer acceptable." For some individuals, a safe, simple and attractive method to interrupt this repetitive confusion and pain is to adopt a contemplative practice such as meditation, tai chi or yoga. Most Windhorse clinicians have experience with the contemplative practice of Buddhist/Shambhala meditation. This is a simple discipline of attending to, or

watching, one's state of mind, without judgment. This can be done formally in periods of "sitting practice" and also informally in the midst of ordinary activity as a person goes about their day. (Mipham, 2003)

First, one simply learns to tolerate how it feels to be aware in the present moment, and how it feels to be with whatever is going on in one's life without self-conscious judgment. Over time, one develops the ability not to be overly carried away by strong positive or negative thoughts and feelings. As our minds become more settled, we develop clarity and awareness. With this comes a heightening of insight, or "islands of clarity," as we call this phenomenon in the course of Windhorse Therapy. (DiGiacamo & Herrick, 2007) Tolerating and appreciating insight is a basic life skill, and it is essential to any process of recovery. As a typical contemplative process continues, healthy self-love is discovered. This is called "maitri" in the Buddhist tradition. (Chodron, 1997) Maitri is the experience that one has basic intelligence, warmth, compassion, good intentions, and the brilliant capacity to love and forgive oneself for not living up to the external sources of judgment that can cause so much suffering and self criticism. Maitri is an innate part of our basic humanity and fundamental health. Once recognized and part of a person's awareness, the experience of maitri is frequently a turning point in the path of recovery.

As the contemplative process continues, one also discovers a naturally confident energy, "windhorse," that can be used in the service of countering hopelessness, depression, and the mindless repetition of habitual patterns. This discovery is actually noticing an old friend and ally. We've known the experience of feeling confident, less conflicted, with a sense of the workability of our life. However, prior to this recognition of windhorse, that kind of experience might be fleeting or haphazard, with only a sense that it was somehow connected to the flux of external events that make us feel good or bad. What we discover at this point is that we can actually cultivate windhorse through our contemplative practice, as we have more of a continuous and conscious connection to our fundamental sanity.

In contemplation, as in recovery, the more we see our lives and ourselves clearly, the more we have a sense of which actions and thoughts lead to a harmonious life and which lead to suffering and unnecessary confusion. Making skillful choices, and rousing the confidence to implement them, becomes an emerging discipline. (Kneen, 2002) In Windhorse clinical practice we refer to this emerging discipline as having an allegiance to sanity. (Podvoll, 2003) With the powerful experiences of being more mindfully present, insight, maitri, windhorse, and allegiance to sanity, it's natural to feel that our personal recovery from a confused state is not only possible, but likely.

A thoroughly trained Windhorse clinician has direct experience of the process described above. One result of this contemplative foundation is the clinician's personal conviction that synchronization with one's basic sanity and health is possible for all human beings. It is also clear that the more one knows one's own mind, the more one has insight into and compassion for how others minds are working. This is not academic knowledge for the clinician, but lived experience.

As the contemplative path develops, it becomes apparent how much we affect and are affected by our friends, family, household, and the way we are in the world. We see clearly that as individuals we are inseparable from the

powerful effect of our environment. This insight has had a significant influence on the methodology of Windhorse treatment environments. We recognize that our clinical work with a person's specific mental health and life issues is inseparable from how we *treat* the person's environment in order to promote recovery.

From contemplative practice, we also know directly that there is no end point in contemplation after which we have no more problems or suffering. Instead, we have tools to work with whatever comes up in our life. Synchronization with our fundamental sanity and health becomes a way of life in relationship to ourselves, our friends and family, and our environment as a whole. Fundamentally, we haven't become something different; we have become a more integrated and harmonious version of who we basically are. This is also how "recovery" is defined in the Windhorse Therapy process: the client achieves a way of life, unique to them, that is synchronized with their fundamental health and sanity. As we will later discuss, in a Windhorse treatment the evolution of this synchronization is uniquely shared by the client and the clinicians.

### Creating Tailored Environments of Sanity

In order to clarify the therapeutic methodology of "treating" the client's environment, Windhorse defines environment as having three aspects: *body, speech, and mind*. (Rabin, Walker, 1987) This way of organizing our perception and experience of environment is based on the traditional Buddhist approach of categorizing phenomena. *Body*, very simply, has to do with a person's body, how s/he dresses, and any aspect of their immediate physical world. This includes their home, eating, exercise, use of drugs and alcohol, and how s/he handles money. *Speech* is about literal communication with the world, emotions, creativity, and relationships. *Mind* has to do with how one thinks, attitudes toward oneself and others, spirituality, and schedule.

When we are called to meet with someone who has been struggling with some sort of mental health and life issue, it is very common to see the following kind of situation. On the *body* level, the person's apartment may have become a very disorganized place. It is unusual to keep a good place to live when you don't feel well or you're very stressed, or somehow absorbed into states of mind where you don't notice what's around you. There may not be regular cleaning going on so the place feels dirty and uninviting. Clothing is not being washed enough. Getting and preparing food isn't regularly done, and what is eaten may not be nutritionally sound. Any form of regular exercise, even going for walks and getting enough fresh air, can be neglected. It is very common for money to be a problem as well. Even if one has enough, without a sense of budget or adequate tracking of what one has and what is spent, the chaos of running out of money, bouncing checks, and not feeling clear about what one has is a very unsettling stressor. Drugs and alcohol are very often a contributing factor to one's life circumstances being in disarray.

On the *speech* level, communication is often very strained between this person and his or her parents. It's not that they don't love each other, but there are so many problems that need working with that it's become almost impossible to have a normal conversation due to anxiety and concern. On the part of the son or daughter, s/he is angry and frustrated because s/he wants to be independent from the parents, but s/he still needs help in many ways. And the parents may

be the only really reliable people in their life. Also, it's very common for this person to be socially isolated, and what friends s/he has may have a variety of problems themselves, which can have negative consequences when they get together.

On the *mind* level, often people who have had creative and meaningful intellectual lives find themselves cut off from these disciplines and all the feelings of success and confidence that come from being engaged in these aspects of their intelligence. Sleep is often either dis-regulated or one is sleeping very little at night and a good deal during the day. There is not enough for the person to do, and not a good schedule for meaningful activity, like a job or school. All this combines to make one feel very disconnected with the world, and terrible toward oneself. When a person feels this bad, s/he believe s/he is actually bad. If one is a sensitive person, and so many who are struggling like this are profoundly sensitive, the intricacy of how interconnected and self-sustaining these problems of environment are, creates a hopeless state of mind. At this point, windhorse energy is deflated and there is little loving kindness toward oneself. The client and family who are in this state frequently have no sense of how to begin the recovery process. The Windhorse approach maintains that in order to break out of the variety of cycles and compounding feedback loops built into this life predicament, it is most effective if we work with all aspects of a person's needs and environment concurrently. This is where the methodology of an individually tailored recovery environment comes in. Each individual and each family is unique, and their strengths and difficulties can be simultaneously held and engaged, in a living arrangement that feels as much like normal life as possible. (Almaas, 1998)

Windhorse Therapy can appropriately be conducted by a very small number of clinicians, using the same fundamental view as a fully developed team. However, in order to illustrate how a recovery environment is assembled and operates, the following examples describe a fully developed team.

### The Compensatory Function of a Recovery Environment

"What we can do for others is create a positive environment in which they can discover their own wisdom and heart of compassion and work toward their own enlightenment. We can provide support for others to find their path, and once they have found it, help them to walk along that path, in the same way that parents do when they support and guide their children: never giving up on them or their inherent potential to awaken to a genuine and lasting happiness."

Dzogchen Ponlop (Brilliant Sanity, pg XVII)

When we create a recovery environment, we are actually forming a very specific arrangement of elements and relationships, with a beginning, middle and end. We attempt to create an environment that holds all aspects of the client's life, within optimal boundaries that are permeable yet containing, between him/her and the outer world. This environment is a comprehensively coordinated organization of body, speech, and mind, comprised of the household, the people and relationships, therapeutic methodologies, schedules, intentions, and awareness. Influenced by the Buddhist concept of mandala, defined as a total environment, association, "orderly chaos," or "gestalt" (Trungpa, 2003), in practice a recovery environment functions as a compensatory, external, organizing entity.

To illustrate, an individual or a family requests that we set up a treatment. Generally there is a person who is designated as the client, and s/he has the most obvious needs. Often, as was described earlier, the client's life is marked by confusion, disorganization, and not being able to create and sustain positive change. With this person's circumstances in mind, we look at what will be required to join with them in a way that feels safe and familiar to them. What will it take to become an ally for them? If they let us, how will we create order in a way that is not too invasive, and therefore tolerable? How do we set up a household that is orderly, comfortable, and uplifted? How do we help them to eat better, exercise in healthy ways, stop bouncing checks, and relate to doing laundry again? If relationships are a problem, either because they are the wrong kind or they don't exist, how can we begin to bridge the loneliness gap by being in genuine and healthy relationship with them? If family relations are strained, how can we help everyone find the right distance and, over time, work to repair damage to trust that might have been done? What are the specific psychological treatments needed? Finally, if the person is feeling no confidence in their own basic sanity and goodness, and no sense that there is a way out of their predicament, we know differently. As clinicians we don't preach this, but when a client is in the midst of people who see the client's sanity and know they can recover, over time it's contagious. In order to accomplish this compensatory function, the components of a recovery environment need to be able to think, communicate, adapt, feel, be organized, conduct a psychological treatment, handle money, know limits, function on all levels in a synchronized manner, and be strongly committed to the process of the client, the family, and the entire team. The recovery environment includes the client and their family as completely integral parts, and it interrupts confused patterns of body, speech, and mind as it begins to function in a way that is more synchronized and healthy. By becoming part of the recovery environment, the client and family begin to experience life in a way that begins to interrupt the existing dysfunctional life patterns.

In many ways, families naturally work this way. If a family member has a life situation, for instance a woman has a baby, it is very hard in the first few weeks for the mother to be able to shop, cook, clean house, and take care of all the baby's needs. There is a good chance the mother's sleep is disrupted, and there is simply not enough energy to do the tasks of life in the way that has been normal. It is very common under these circumstances for partners to take time off from work in order to make sure that everything in the life of the mother, child, and household can be accomplished as necessary. Other family members and neighbors may also help out. In this case the mother and the baby are the focus, but anyone who is helping out will do their best to do so in a balanced way, so they themselves don't lose their health in the process. Like a Windhorse recovery environment, this family system is compensating for a change that has occurred, and there is a sense that this is a transitional phase.

### Therapeutic Elements and Roles

In order to create the compensatory recovery environment, a team is gathered made up of the clinicians, the client, and whenever possible, the family. These people work in a complementary system of roles, each carrying out a range of functions that develop, maintain, evolve, and "are" a large part of the

environment. The cohesion and communication of this “gestalt,” or “whole person system” is carried out within the household, the meetings, and the relationships of the team. In order to understand the context for much of the relationship activity of the team, we will now look at basic attendance.

### Basic Attendance

A highly flexible and innovative clinical practice, basic attendance is the principle therapeutic activity in a Windhorse recovery environment. Influenced by the Buddhist practice of being attentive to, or simply watching the mind without judgment in the midst of everyday activity, basic attendance is: Being actively, and with helpful intention, in relationship with someone in the broad spectrum of their life activities, in order to promote the synchronization of their body, speech, and mind, and connection to their fundamental health. Stated by Podvoll, “The work of basic attendance requires more than just what one knows, it requires that one use everything of who one *is*, and how one relates to the world. A deeper set of clinical skills needs to be cultivated to do basic attendance properly. It is not merely a disciplined “hanging out” (though at times that is just what is called for-and actually may not be so easy to do.) Simply said, basic attendance is “getting down” to what is immediately relevant to being with someone in the process of recovery--whatever may be required, from taking walks to something approximating more traditional psychotherapy.”(page 265) As the most active and apparent clinical activity of a recovery environment, it involves being with clients in a wide range of activities in and out of the home. This can range from the ordinary domestic activity of a household, to doing art, signing up for classes, looking for work, or simply having time to relax and play. These activities are done with the intention to help a person be more aware and in the present, and of course to promote health and recovery as it uniquely applies to their life.

### Clinician Roles

The work of a *basic attender* may look very simple to the untrained eye, but as anyone knows who has done it, a seemingly simple task for the client, such as cooking a meal, can stimulate a powerful profusion of conflicting thoughts, emotions, and growth frontiers. It can take a great deal of skill and sensitivity on the part of the basic attender to create a safe and successful experience. Given that basic attendance can involve a wide variety of activities and settings, often with complicated boundaries and treatment needs, it is a subtle and complex form of clinical work.

In the development and maintenance of the body level of the environment, the basic attenders work to establish an orderly, normally functioning household, with regular food preparation, a cleaning schedule, and a well-run budget. They help the client to have a reasonable amount of exercise, good nutrition, and if medications are involved, support their regular and organized use. Within a basic attendance shift, it's very common for the checking account to be balanced, for medications to be picked up and organized, or for a maintenance issue with the house to be accomplished.

The speech level is where so much of the therapeutic value of basic attendance works. Alliances and continuity of relationships with healthy people

work as a powerful glue from the beginning to the end of a recovery environment. Over the course of a basic attendance “shift,” which usually lasts two to three hours, the client is with someone whom s/he hopefully enjoys and with whom their social life is enriched. There are often opportunities for role modeling as the basic attender and the client set out to do tasks in the home or in the outside world. Frequently as thoughts or questions arise for the client, informal therapeutic discussions can be very accurate and meaningful because they occur in the moment that an issue arises. Besides the things that simply need to be done in order to keep the world of the recovery environment organized and synchronized, basic attenders are always on the lookout for activities that connect with the client’s passions, disciplines, creative outlets, and sense of sanity and confidence. Often we see a basic attender’s relationship with the client develop tremendous depth and subtlety over time. The accumulation of shared experience in which the client contacts their own sense of basic health, insight, maitri, and windhorse, and thus confidence in their own recovery, often develops into a profoundly meaningful relationship between the client and a basic attender.

The primary coordinator of basic attendance activity is the *team leader*. The clinician in that role needs to be an experienced basic attender. S/he has been involved with enough Windhorse treatments to have a good sense of how a team works together and how that changes over time as a treatment progresses. The team leader also does basic attendance shifts. As such, their work occurs mainly in the body and speech levels of the recovery environment. S/he needs to be very attuned to details of the activities and logistics of the recovery environment, including the schedule. We train all basic attenders to be familiar with the specific psychological disorder that may be involved with the treatment, but in the case of the team leader, a level of expertise and familiarity with the particular disorder or disorders is more critical. As the supervisor of the basic attendance, s/he needs to be very familiar with each basic attender’s work, and how to keep the household and basic attenders working in harmony. The team leader is also usually one of the key people in the life of the client and family as a sturdy, dependable, and knowledgeable reference point. S/he provides primary supervision and support to another very important person on the team, the housemate.

The *housemate* is a role that exists to support the health and order of the home and to provide more ordinary and relaxed relationship opportunities within. The housemate, and sometimes we have two, lives in the home with the client. S/he is often a student, or someone who doesn’t necessarily have psychological training but has good judgment, a high tolerance for chaos, and typically a lot of patience and compassion. The housemate must be very open to supervision and learning. S/he usually commits to living in the treatment household for a minimum of six months, although it’s not uncommon for a housemate to stay for up to two years. The housemate’s job is simply to live in the house, support the functioning of a normal and uplifted domestic setting, and by their presence add a deeper relationship possibility with the client. It is quite typical for the relationship between the housemate and the client to look like that of friends who live together, with very little professional overlay, but with good boundaries. Also, by their presence, other members of the team naturally have a more intimate sense of life in the household. Aside from

informing the recovery process, this adds another layer of safety in the treatment, in an informal way. The housemate role is never designed to provide psychotherapy, however, s/he does attend some meetings, which we'll discuss later. This role exists primarily in the body and speech levels of the recovery environment.

*Psychiatrists* are usually part of a team, as frequently our clients are using medications. Some psychiatrists may only be doing medication management, so their involvement with the team could be minimal. Others, particularly those whom we have worked with over many years, can be a critical part of the treatment management. As it is often the case when a client is in one of our treatments, they are able to be on less medication, and their needs change over time. We find that the psychiatrist will have a more subtle knowledge of who the client is and what their needs are, if they are an integrated part of the team structure. The work of the psychiatrist spans the levels of body, speech, and mind.

A Windhorse *psychotherapist* is a highly trained clinician. This is the role Podvoll referred to as the intensive psychotherapist, which evolved from the analytic tradition of Freda Fromm Reichman and Harold Searles, in combination with the contemplative view and experience of working with mind. This discipline is particularly effective in working with people who are experiencing more extreme states of mind, including psychosis. As a fully trained Windhorse clinician, s/he also has the experience of being a basic attender and team leader. The psychotherapist does one-hour therapy sessions with the client, sometimes more than once per week, usually in the office but sometimes in the home. This role has many dimensions, but primarily the psychotherapist is looking for the intelligence and patterns that reside below the often-confused behaviors of the client. This is learned through the work s/he does in sessions with the client as well as through experience in meetings where s/he hears what the housemate, basic attenders, team leader, and psychiatrist describe of their client contact. Likewise, the insights about the client and the recovery environment as a whole that the psychotherapist provides in the meetings helps inform the work of entire treatment team. In this way, psychotherapy, basic attendance, and medication management are highly integrated elements of the recovery environment.

The role of *team supervisor* is held by a senior Windhorse clinician who has experience being a basic attender, team leader, and psychotherapist. Any treatment that requires a fully developed recovery environment, including housemates and family work, is complex and energetic. We find that by having the psychotherapist work with the client and team, and by having the team supervisor work with the family and team, we have a much more complementary, intelligent and aware arrangement. It is also one that doesn't over stress the psychotherapist with either too much responsibility and/or conflicting roles. For example, conflict often arises as the client may not want their psychotherapist talking much, if at all, with their parents. It is the role of the team supervisor to track and be aware of the overall therapeutic process of the recovery environment. S/he watches the dynamics and patterns of the team as the treatment moves through the phases of beginning, middle, and end; s/he educates as necessary the team around any aspect of working with the mental health conditions being treated; s/he works as a complementary part of understanding and nurturing the client in their recovery; and s/he works with

the family members as they make their own recovery journey. The team supervisor also has a key role in creating an initial “visualization” for the team and the entire recovery plan. There are times when the psychotherapist and the team supervisor role are combined, but only if it does not compromise the strength, sustainability, and therapeutic structure of the recovery environment. From the body, speech, and mind perspective, the psychotherapist and team supervisor work primarily on the level of speech and mind.

### The Therapist-Friend Relationship

In most psychotherapeutic disciplines, treatment occurs in an office. In a Windhorse recovery environment, particularly with the basic attender and housemate roles, the formality and boundaries that are a normal part of how most psychotherapy operates would seem altogether unnatural and stiff. As this is the case, we intentionally acknowledge and cultivate client relationships that are part friendship and part therapist. In fact, as we select which clinicians may be on the client’s team, we’re careful to select people we think the client will actually really like, and vice versa. (Podvoll, 2003)

The therapist-friend relationship has a number of benefits. First, it will make spending longer periods of time in basic attendance more relaxing and fun, much more like normal life than therapy. And we want our recovery environments to feel like, and, in fact, to be like normal life. Secondly, many of our clients have had a very difficult time forming treatment alliances. Having clinicians that they feel some sense of attraction to as friends may make it possible to join and stay in treatment. A natural part of how friendships often happen is that people with similar interests enjoy those activities together. When selecting team members, we pay attention to what interests the client has and attempt to have clinicians who may share those interests. In this way, part of the basic attendance activity is often “jump starting” a dormant passion and discipline in the client’s life. Thirdly, it opens up the possibility of being able to bring a client into the basic attender’s household. Whenever appropriate and in well-considered measure, Windhorse clinicians will often invite clients into the world of their families and homes. This can have a very powerful role modeling effect for the client as they see the home and relationships of their “therapist-friend.” (Fortuna, 1987) Being included this way can help a client to feel more like what they are; that they are a good enough and trusted enough person to be included in the world of their high functioning friend. Altogether, basic attenders can become like respectful friends, with intelligent boundaries, who also have a therapeutic role.

Along with the benefits, there is also no question that the therapist-friend relationship can develop a type of tension, which we call the therapist-friend dilemma. This dilemma can manifest in a variety of ways. Sometimes a client may want to take a relationship further than what professional ethics would allow, further than what the basic attender might feel comfortable with, or further than what the team leadership feels is therapeutically appropriate. This can be a painful reminder that this relationship has limits. Another aspect is that for some clients, having a team can be a reminder that “my life has sunk to the point that I need paid friends.” There can be an unsettling awkwardness in the therapist-friend dilemma that often also helps the client from getting too complacent in treatment. “This is not the way my life is going to be forever, and

it is a bit strange having friendships with these people who are paid and who have limits in what we can do together. I look forward to getting out of this treatment and having my ordinary life back.”

### Mutual Recovery

A treatment element related to the therapist-friend relationship is called mutual recovery. (Podvoll, 2003) This originates with the contemplative training of a Windhorse clinician and his/her own process of recovery and practice of synchronization. As Windhorse clinicians, we aspire to include whatever we are doing as part of our recovery path. We may be therapists, but there is seamlessness about how we try to conduct our lives, whether at work or at home. As Trungpa stated in his work *Creating Environments of Sanity*, “You don’t just regard psychology as a J.O.B.” (p. 551) This means that we conduct our professional work as clinicians in fundamentally the same way that we live our lives. This promotes a sense of inclusion of everything in our personal discipline, a “sacred world” orientation (Kneen, 1996), to borrow a Buddhist concept, where “sacred” doesn’t mean precious or rare, but what reminds you of your basic sanity and goodness. Since everything is included in our view of how we live and work with our lives, our relationship with the client is naturally part of this. Instead of “I’m well, you’re sick, and I’m going to fix you,” there is a sense that we are in this together, and we all are working on our humanity. In some ways, this is similar to how a person recovering from an addiction to a substance, for instance alcohol, may have particular insights and credibility when working as a therapist in that modality. The therapist in recovery will always be working their own path, and those in treatment know s/he is not just working from an academic knowledge base. For potential clients who have difficulty forming treatment alliances, this element of mutual recovery can make it easier to relax and bond with Windhorse clinicians.

Within the basic attendance interaction, the elements of mutual recovery and therapist-friend provide a way for the client to see and hear more of our personal process as s/he gets to know us in the world, in our homes, and with of our families. Our struggles may show more in our roles as spouses/partners, parents, and friends. If the client is watching, it will also likely be clear that we are growing as people as a result of being with them, with all the rough edges that can come with that kind of process. It is enormously heartening to some clients to see their therapists being imperfect people who have their own pain and awkwardness in the world.

Speaking personally, I know some of the most therapeutic work I’ve done with clients has been when s/he sees me making mistakes either at home or in the clinical setting. Witnessing my genuine discomfort and how I deal with it puts me in a much more human and vulnerable light, more like him/her. Now the client is “not the only one around here who screws up.” Beyond that, being able to model how to relate to my own errors and imperfection offers a wealth of behavior modeling. Do I own the error or try to evade responsibility? Do I beat myself up or offer genuine self-forgiveness? Sometimes, I would be very self-critical and would eventually experience self-forgiveness, but not before my pain was evident in an unguarded way. Even with this awkwardness, usually my own practice of being direct and genuine with myself was further along the recovery path than that of my client’s, and I know that it gave him/her new and

less aggressive examples of how to work with his/her own imperfection. And, sometimes s/he would offer me advice that was wise and mature: helpful both in the relief of my suffering and to my growth as a person. It is enormously heartening for the client to see their therapists growing as a result of being with them.

### Meetings

Now that we've looked at the individual clinical roles and related therapeutic elements, we will discuss how these activities are held together in a coherent form. In a recovery environment, meetings play a completely critical role. There are a variety of meetings, and all are designed with complementary functions to enhance the communication, cohesion, synchronization, and awareness of the clinical team, the client, and the family. Of the types of meetings generally conducted in the course of Windhorse Therapy, these four--the house meeting (includes the housemate, client, and team leader), the supervision meeting (includes all clinicians without the client), the team meeting (includes all clinicians plus the client), and the family meeting (includes the relevant family members, client, team supervisor and/or psychotherapist)--have the most central roles. (Fortuna, 1987)

The *house meeting* is held on a weekly basis in the household, and as mentioned, is attended by the housemate, client, and team leader. Its primary function is to cultivate the understandings and operation of an uplifted but very ordinary-feeling home. Food, money, housecleaning, how one uses the kitchen, how one eats, how one cleans up after oneself or not, buying groceries, and tending to the yard are the sorts of things that go into cultivating a coordinated household. Helping the client and the housemate communicate with each other around these tasks is a large part of the work of the house meeting. As anyone knows who has ever lived with another person, it's a normal part of a household for relationship irritations and misunderstandings to arise. This meeting is the place where so much of the intimate relationship-work between the client and the housemate is supported

The *team* and *supervision meetings* have overlapping and separate tasks. Looking first at the *supervision meeting*, we gather at an office, usually on an every other week basis, in alternation with the team meeting. The entire team, except the client, is present, often including the psychiatrist. The team leader runs the agenda and makes sure that all elements needed for coordination of the recovery environment's activity for the next period of time are addressed. Schedule is always a large part of this. These meetings typically have a relaxed but precise focus, often with good humor. We try to really look at each other to see how everyone appears to be doing, and we make a point to ask if someone looks out of sorts. We also frequently do a check-in about each clinician's activity with the client and family from the time of the last meeting. This tends to "bring the client into the room." We then have much more of a feel for how the client is doing, and the emotional tone of the relationship with each clinician becomes more present. For treatments where there may be a tendency for relationships to be conflictual, this check-in can be a lifesaver as it keeps everyone talking and sharing whatever difficulties s/he may be having. We also encourage clinicians to take risks with saying whatever s/he is thinking and feeling, because it is so

often the odd and even embarrassing experiences that are most informative for how the client is doing, how we may need to care for that clinician, or the next steps the therapy may need to take.

**Some Supervision Meeting Dynamics:** The dynamics of mind in a supervision meeting are remarkably energetic, complex, often subtle, at times not, and can generate a wide range of feeling experiences. For those who are paying attention, a wealth of information about how the client is doing and what is going on altogether in the recovery environment is available. Likewise, if one is not paying attention, supervision meetings can become quite dangerous to the treatment. We will focus on two prominent aspects of this dynamic, and attempt to explain often murky and overlapping treatment phenomena without over simplifying or solidifying them.

**The Phenomenon of Split Transferences:** Over the years of working in supervision meetings, we have come to recognize that each team member establishes very different and individual relationships with the client. It's obvious that this should happen, but the observed implication is that as the client relates to each therapist-friend, a different part of the client's mind is engaged and revealed through the relationship. When any individual therapist works with a client, often a transference develops. In this case, when one client is working with a team of clinicians, transferences often develop unique to each clinician, which we refer to as split-transferences. (Goldberg Unger, 1978) After a time of working together, through the process of split transferences, the clinicians frequently take on identifiable family system roles. We see the roles of siblings and parents most often, as over time the client's and family's dilemmas tend to be inhabited by the team. Through these split-transferences we often see elements of the client's mind come forth, maybe only briefly, of which they, or we, have not previously been aware. As each clinician--with their individual relationship with the client representing an aspect of the client's mind and personality as a split transference --comes together in a meeting with the other split transferences, "the client's whole mind" is now in the room and able to be more aware of itself than it may otherwise be. As this happens, there is a chance for us to see what sorts of tensions and dynamics might be present. For example, we see what role in the transferential world might be particularly irritating to whom today. I want to highlight that we do not pigeon hole ourselves into fixed roles, and we are very careful not to invest our feelings with too much meaning when split transferences become vivid. Dangerous divisions in the team can develop if clinicians begin believing their thoughts and feelings are actually solid. Split transferences have the potential to calcify into conflicting, treatment destructive sub-groups.

An example of this occurred recently for a young woman client who experienced her father as distant, punitive, prone to demanding too much of her, and insensitive to her desire to have a psychological treatment that was non-traditional. In contrast, she experienced her mother as very nurturing, always supportive, and generally willing to "protect" her from her father. In her treatment, the psychotherapist transferentially became her mother and the psychiatrist became her father. The psychotherapist found himself to be suspicious and resentful of the motivations of the "medical model, overly stuffy and arrogant psychiatrist" who wanted to impose her ideas on the client without

genuinely understanding who she was. The psychiatrist perceived the psychotherapist as a dimwitted and spineless enabler. It didn't take long for us to catch on to what was causing these feelings, as we had adequate meeting contacts, and the psychotherapist and the psychiatrist were mutually trusting colleagues. This experience gave us insight into the potency of the split in the family, which had previously not been very apparent. There was truth to the family split, as well as exaggeration on the part of the client as to how black and white the situation was. Over time we helped the family become less polarized and helped the client see her parents in less good and bad terms.

We have built in antidotes to solidifying such feeling polarities, as from our individual contemplative experience each clinician knows thoughts and feelings to be insubstantial. Also, part of the task of the senior clinicians is to help the team remain aware that even though thoughts and feelings may be horrendously painful or compelling, we can relate to them with curiosity, gleaning the intelligence they might contribute to the treatment. We've seen so many examples of split transference relationship polarity that we are vigilant not to be blind-sided by the destructive aspects and equally to take advantage of the information they offer.

The *team meeting*, with the client present, is often held in the client's home. We are very careful to tailor this meeting to the client's needs and sensitivity. Some clients can participate comfortably, with all of us being relatively direct and forthcoming in our communication. Others need more emotional insulation and a less stressful meeting environment. And some can't, or won't, participate for some time. When it feels right, we always encourage a client to join in.

In a team meeting we are looking for what form will be most comfortable and productive, while sustaining enough tension to produce therapeutic work. Sometimes we just work the agenda in a normal way, and do our best not to overwhelm the client by placing too much attention on him/her. For others, we might spend a good deal of time with refreshments in order to create a more relaxed social environment, once again, trying not to make the client the center of attention. Sometimes this type of meeting can have a personal check-in, where everyone on the team takes some time to talk about what is going on in their personal life. This is always done with discretion, but given the therapist-friend relationship, and with some of our teams lasting many years, the mixing of our personal lives can be a relaxing and normalizing aspect of relationship.

Beyond the potential therapeutic social aspect of the team meeting, and the very practical coordination work, variations of the dynamics of the supervision meeting are also at play. The complete view of split transferences is now right before the client's eyes. This provides a chance to experience and integrate different aspects of themselves, and to see these clinicians more as "people" as they interact outside of the transferential intensity of the dyadic basic attendance relationship. When the correct balance is struck between being direct and keeping the stress manageable, clients typically experience team meetings as building confidence in their process of recovery and in their voice as an important part of the team.

Everything mentioned so far about Windhorse Therapy could have the preface, "It all depends on who the client and the family are." That statement most emphatically applies to how *family meeting* works. Many of our families are out of state. Some families have divorced parents, so there are communications

and responsibilities that may span different states and a variety of relationship histories. One or both parents may be dead, the client may be completely estranged, sometimes there is harmony, and sometimes there is a lot of relationship work to be done. Invariably, the problems that appear to center on the client have had an effect on the family system and vice versa. Our work with the family system is part of the compensatory environment. It is frequently the case that there may be very strong feelings on the parts of both the parents and the client. In those cases, we may need to compensate for the family tension by creating some insulating distance between the client and the parents, and by helping with communication as needed. We may not actually do sessions with them together, either in person or on the phone, until the tension calms to the point where the meetings are productive. In such cases, we work individually with the parents, assuming that's where the primary family relationship work is to be done. It's critical to hold these meetings in a proper rhythm, which can change as the treatment changes. Often speaking every two to four weeks is necessary to keep the parents abreast of what's going on with the recovery process and to help them feel heard and understood as participants. As we are able, we begin family meetings that include the client and the family. Given that family circumstances and their readiness for therapy have so much variation, these meetings are always carefully tailored in their form and frequency. (Miklowitz & Goldstein, 1997)

We can say with certainty that for all treatments we conduct, the process of recovery changes the client, the team, and the family. To make this possible, it's essential for a proper communication form to exist where the voices and intelligence of all three of these major components of a Windhorse treatment can be heard. Just as the confidence we have in the basic sanity of the client has an effect on them, our confidence in the basic sanity of the family can help the family with feelings of guilt, self-aggression, and hopelessness. In family meetings, we attempt to create environments where gentleness and windhorse energy are present for all involved.

### The Phenomenon of Exchange

As we look at the dynamics of Windhorse meetings, it is necessary to discuss the phenomenon of *exchange*. (Podvoll, 2003) The atmosphere of mind in the recovery environment is created by all the people involved. This occurs through the process of what we call *exchange*. The presence of one's mind does not just exist within our cranium. There is a presence of a person's mind that can be felt when around that person. When paying attention, we have all had the experience of noticing how our mind feels and works differently around different people. For example, with some we might feel more competitive or less sure of ourselves. With others, we might think more clearly or just the opposite. The process of exchange is that mixing of minds that happens when people are together. (Goleman, 2006) For instance, in a meeting, typically at some point one has a mental or physical experience, and it's completely impossible to tell who is the source of what. But if you are aware enough of your own mind, and if you make a practice of being clear and attentive to the mind atmosphere of the recovery environment, you will notice patterns that seem unmistakably specific to that situation. Exchange happens in dyadic encounters as well as in group

meetings, and it seems to be most heightened in the mind atmosphere of meetings.

The phenomenon of exchange is often a subtle experience, with maybe only minor variations of how you might normally think or feel. For example, with one client in particular, when I was in her supervision meeting my mind was generally unusually clear. Whatever I was thinking about displayed itself with much more insight and detail than usual. It felt like what I imagine having a very high IQ would be like. That quality of mind I experienced was a sane aspect of the frighteningly powerful and complex mind of this person. With this same person, as a group we would often be trying to control her in unreasonable ways, which was what she frequently tried to do to us as her treatment team. The mind element is too fluid to make such experiences of the phenomenon of exchange completely reliable, but the ephemeral reality of experience and insight triggered in Windhorse meetings offers highly valuable knowledge about the client and the team.

One particular aspect of exchange in a meeting can look similar to the example already mentioned in split transferences, where clinicians become polarized. In the case of polarized feeling states that seem to arise from exchange, the individuals involved may not have any identifiable transference roles. A powerful example of this phenomenon occurred with a treatment that had been in existence for several years. We could see that the client was struggling with wanting to take risks with new behaviors. These would have made him feel much better in many ways, but he would have had to raise his commitment to responsibility and accountability to a higher level. As his hesitation was discussed in various meetings, we identified some extreme feeling poles among the clinicians. Two in particular, represented the tension between the client's strong desire to progress to a higher level of functioning and his self-criticism and condemnation that he was hopelessly incapable of such growth. This is a polite way of stating that the two individual clinicians who held opposing views felt like they hated each other. I was the person who held the view that the client was capable of taking the next steps and my colleague and friend of many years, whom I had great respect for, and she for me, felt just the opposite. As these feelings escalated, for weeks I really hated to even look at the other clinician. It felt injurious and insulting. I wanted her off the team as she was damaging my client who had so much potential for growth. She, on the other hand, thought I was being reckless to encourage the client to attempt such growth steps, irresponsibly setting him up for failure, which could produce long-term damage to his confidence and self-esteem. She wanted me off the team as well. No one else on the team of about 10 clinicians was feeling anything like what she and I were experiencing. When we finally recognized that we had been holding these polarities, we were relieved that we understood what was going on and that our friendship of many years wasn't on the rocks. We also were stunned and heartbroken by the vicious and murderous intensity of the struggle that our client was having between her progressive and regressive impulses. As with split transferences, the information that exchange can produce has the potential for very positive effects on the treatment, or equally destructive effects if one is not aware and paying attention to this aspect of group mind.

## The Phenomenon of Group Windhorse

Meeting participants often show up for a meeting having done a lot of individual work since the last gathering. We may be feeling isolated and road weary. The basic attenders, team leader, psychotherapist, housemates, team supervisor and the psychiatrist, have all had their experience of client, family, and each other, over the last period of time. The client and family members likewise have had to deal with the team members and with each other. Feelings have developed, questions have come up, perhaps a troubling observation needs to be discussed with the group. Intense emotional energy may have arisen for some. When all of us get into the room together, we have a chance to hear and feel what is going on with each other and to explore personal experiences in the work. Split transferences may show, exchange experiences may be there, and a significant task for the group is to help everyone say what's going on for them. No matter how negative, painful or hopeless it might sound, we all need to feel heard and to be connected to the whole. From there, we try to make sense of our feelings and experiences as they relate to our developing understanding of the environment and this unique path of recovery. Once the individuals feel heard and connected to the whole, feelings generally aren't experienced as being quite so solid. We are usually able to make sense of our experiences and have an understanding of how they fit into the overall treatment. At this point, there is nearly always a sense of relaxation. With relaxation and clarity often comes the experience of heightened creativity and windhorse energy being aroused in the group. (Gaviotos, 1998) This phenomenon of "group windhorse" is an experience of certain qualities of mind being heightened -- upliftedness, confidence, compassion, creativity, and not being fixed on difficult thoughts. The clinicians gain clarity with this experience, and it is directed back to the client and family in our individual contacts after the staff-only meetings. In the meetings involving the client and family, they too help create and *exchange* with this heightened positive atmosphere of mind, gaining experiences of clarity, compassion and windhorse.

Through the complementary functioning of this variety of meetings, clarity, coordination, and confident life energy is strengthened in the clinical team, the client, and the family. Meetings maintain the pulse and breath of the recovery environment.

## Case Study

Since Windhorse Therapy is a complex process uniquely tailored to the individual client, a case study will provide a sense of how treatment actually looks and works.

Julie was a 27-year-old woman whom we worked with for about two years. For the five years prior to our first meeting, since her first manic episode and hospitalization (she had now been hospitalized seven times), Julie had denied that she needed psychological treatment. What was different about her current hospitalization was that for the first time she said she was tired of being "thrown in the hospital" and wanted some help. The hospital thought Windhorse Community Services could be a good resource, and her mother called us.

I spoke with her mother, Beth, who was in a guardedly hopeful state of mind, but also heartbroken, bewildered, and exhausted. As she had never heard Julie say she needed treatment, this was stunning. She had been hoping for years that Julie would say this and actually follow through. Beth was almost afraid of this little ray of hope and the thought that “I might be finally getting my daughter back.” I described our approach to working with people, how we can very specifically tailor a treatment to each person, and that many of the people we work with, for a variety of reasons, had not found success with previous treatment experiences. While being careful not to create false hope, I told Beth that one of the things Windhorse clinicians are very good at is making treatment relationships with people who have had a hard time with this. The therapist-friend and mutual recovery concepts made complete sense to her. Beth spoke with Julie and she agreed to meet with me. With that, we hoped for the best, and I met Julie at the hospital the next day.

Julie was a petite person, about 5’4”, around 125 pounds, but looked physically strong. She had a pleasant face, and the ruddy, fair complexion of someone who had spent a lot of time outdoors. Our meeting didn’t last long as she immediately told me that her mother had described what Windhorse does, and that sounded fine to her, “just to get everyone off my back.” She said she really didn’t need treatment but would agree to work with us for six months. It felt like she was commanding me to listen, not interrupt, and not to make eye contact or say anything that would put her on the spot. I complied with her “commands,” asked her if it would be OK if I started introducing her to potential team members while she was in the hospital, and she said a bit dismissively, “of course.” “Do you have preferences for men or women on your team?” “It doesn’t matter, and anything you need to know my mom can tell you. Are we done?” Though she was outwardly a bit hostile, I found her quite likable. I could see it was unspeakably difficult being in her situation and having to talk to someone like me, and I thought she did a good job of getting to the point and taking care of herself. It also looked like she had a lot going on inside. I left with the impression that Julie was terrified, feeling completely alone and vulnerable, and making a tremendously courageous effort to try something different in her life.

Once someone agrees to work with us, we conduct an assessment in order to know what kind of recovery environment needs to be created. In an assessment we try to grasp a whole person understanding of who our potential client is. This includes attempting to understand their family, their history of difficulties, and very importantly, their history of sanity and success. (Podvoll, 2003) Out of this, we then know what type and size of treatment is needed, and what clinicians s/he might be most compatible and interested in working with.

From all we could gather, Julie had grown up quite normally as an energetic, intelligent, athletic, and creative person. It sounded like she had begun to experience mood instability late in high school, seeming depressed with lower energy, and at times needing to withdraw a bit from her usual lively flow of activity. Once in college, Julie continued to do well in all areas, but her mood irregularity became more pronounced. Sleeping was often difficult, and it was harder for her to keep an energetic schedule. Her art at times became more brilliant and subtly expressive, but she also did less of it. She tried medications for a brief period, but rapid weight gain and unimpressive results convinced her that they weren’t worth the trouble and she stopped. In the meantime, Beth and

Julie's father, Mike, were in the midst of a fairly amicable divorce, which resulted in him moving out of state and essentially out of her life.

After a heroic struggle to stay in school, and with her life badly deteriorated from how she had been at the beginning, she finally graduated from college. Shortly after that, Beth visited her and immediately knew something was terribly wrong. Julie was talking in a rapid and pressured way, was very irritable, and was speaking in an urgent manner about what sounded like Christian mysticism. Her apartment looked like someone had ransacked it. It appeared that Julie might not have been sleeping for awhile as her bed was now under many layers of oddly arranged artistic creations that appeared to constitute an altar. When Beth urged her to see her old psychiatrist again, Julie stormed out of the apartment and recklessly drove off. She was picked up later that day by the police and was taken to the psychiatric hospital on a mental health hold. Thus began the cycle that would become her life for the next five years: brief periods of stability interrupted by involuntary hospitalizations, medications, weight gain and "stupidity," sometimes a job that was hard to cope with, no friends, no meaning, "mom worried about me all the time," "wanting my life and freedom back," and almost dying on two occasions after intentionally stepping into traffic.

The consensus of the assessment was that Julie needed a fully developed team and two contacts per day to begin with. This is a lot of contact, which could be overwhelming, but we also sensed that we needed a very solid structure for her to actually stabilize and be safe. The contacts would be relatively brief, an hour and a half in the morning, probably around 9:00 – 10:30 AM, to help her get some breakfast and organize the day. She would have another shift later in the day, 6:00 to 8:00 PM, to get dinner and to make the transition from the day to evening. With the day book-ended in this manner, it was also designed to get Julie's sleep cycle stabilized with her awake during the daytime. Beth intuitively understood that this sturdy contact structure was necessary. She also understood, given the intensity and duration of Julie's mental disturbance, that treatment would likely last at least one year, and probably two. As Julie was committing to taking her medications as prescribed, she would handle those herself. We had worked on this plan as best we could with her, but she was clearly not interested in the details of what we would all do. She just said, "I'll do *whatever* for six months."

The immediate work at hand was to create the recovery environment. For the therapist we chose a man named John and for the team leader a woman named Sandy. Both were very experienced Windhorse clinicians with expertise in bipolar disorders. Because Julie was quite intelligent, extremely sharp verbally, and had a severe and deadly mood disorder with psychosis, we knew that we needed skilled basic attenders with experience in bipolar disorder as well. We wanted them to be in their late 20's or early 30's, and we wanted a gender balance. This aspect of staff selection is worth repeating: we're always looking for clinicians who have similar interests to the client's, and whom we think the client will like and vice versa. Fortunately, we found just such candidates and on our first pass through the interviews, Julie accepted them all. We now had three women basic attenders and two men. We also had a woman housemate available immediately, whom Julie liked very much. Rounding out the team was a psychiatrist with extensive Windhorse experience, and myself in

the role of team supervisor. With the team selected, it was now time to gather for our first supervision meeting in order to assemble the schedule and create a beginning vision for the journey we were about to take.

As the treatment began, Julie's terse guardedness with me was in stark contrast to how she spoke in one-on-one situations with John, the therapist, and with Sandy, the team leader. She related to them as if they were her students, and she was a spiritual teacher. She was a little formal, tolerant, and "patient" with how distracted they were by mundane life activity. At any given opportunity, she would "teach" about the spiritual aspects of life, relationship, the universe, and anything at hand that had inspired her. She would let John and Sandy do their work, and she would cooperate and teach them when she could. She related to the basic attenders in a similar manner.

We began the scheduled contact when Julie was still in the hospital, and shortly after she was discharged the schedule began in full. A good deal of the early shift activity, especially for the team leader and the time with Donna, the housemate, was spent finding an apartment and shopping for furnishings. Of anyone on the team, she seemed to have the most relaxation with Donna. It was the least professionally oriented relationship, and they often were just in the house together in a quiet way. They both enjoyed working together to make a comfortable home, and she did very little teaching with Donna.

Julie settled into the basic attendance schedule in what appeared to be a surprisingly un-conflicted manner. She was on time for shifts, didn't seem to get particularly close to people, still did a lot of teaching, and tended to be pretty organized about how the time was spent. She would typically use shift time to do errands, get coffee, take a walk, or organize her art studio. Her psychotherapy sessions, which were once per week, were a slightly different situation. She and John would meet in his office, and before long, she began to be either completely silent, or would show the same kind of guardedness she had with me in the beginning. When she did talk it was mostly to teach.

For our family meetings, we decided that in the beginning we would meet at least every two weeks, but that of course Beth could call me as needed. Julie declined to be part of the family meeting to begin with, although she spoke with her mom several times per week.

Things were going reasonably well for a beginning phase. Her sleep was getting into more of a day-night rhythm, relationships were maturing, and she was eating in what appeared to be a normal manner. She was also beginning to swim as a way of getting into shape again, and she would spend a lot of time during the day walking around town. In the supervision meetings some basic attenders expressed feeling useless and irritated. The shifts felt like a waste of time. My experience was almost always one of vigilance. Despite how easy almost everything about the treatment was, I felt like we were constantly on the verge of something dangerous happening, some disaster. We were also easily able to see what a lovely person Julie was, and her good heartedness showed in many ways. Even her teaching felt like a generous offering to us. It had a touch of a psychotic flavor, but we could see that she really cared about what she was saying. We all really liked her and sensed she had been and continued to be in a terrible life predicament.

The team meetings were held at her house. These were generally not very comfortable, a difficult variation on a basic attendance shift, with Julie needing to

keep the relationships at a safe distance by teaching. The house meeting, also held at the home, was more comfortable and productive as it focused on details of running the home with Donna.

Julie continued showing up for every shift, but as time passed, she was beginning to let it be known that we were all nice enough people but quite useless as therapists. Especially John. There were many sessions where they would just sit with a lot of silence. A little teaching would happen, and then Julie would tell John what a waste of time therapy was. She didn't need therapy, and John was a lousy therapist anyway.

One morning, about two months after being discharged from the hospital, Julie didn't want to get out of bed. Her polite demeanor had been slowly changing over the last month, and she stopped teaching. This morning she looked withdrawn and terrified, like she was really suffering, as if it were difficult for her to breathe. She spent the morning in bed but seemed to appreciate the quiet company of the basic attender, who brought her tea and food and read a book to herself while Julie lay in bed, not wanting to talk. Later in the day she had a therapy session with John, and strangely, she seemed interested in seeing him. At the beginning of the session she was quiet, but it had a completely different feeling about it. Instead of angry and guarded, she appeared completely vulnerable and fearful, very uneasy. Finally in a quiet tone she said, "I can't believe this is who I am." Then in a steady and measured flow of words, she described how horrible it had been over the last five years to see life as she thought it would be completely washed down the drain. She couldn't count on herself, and nobody else could count on her, except to do something crazy, destructive and stupid. She had wanted to ignore it, but the mania kept coming back. She wanted to "leave everything," but the police kept bringing her back. Now she was here and having more awareness than she wanted and John, after having survived so much of her anger, felt like the safest person to be with, at least for right now. Between the depression, which made her feel like a hopeless and utterly bad, worthless person, the insight of what she had lost, and without having any sense of a way out of this horror, she saw no realistic option but to kill herself. She had no immediate plan, but she promised that if she tried again, it would be successful. It was clear that she meant it.

John just quietly listened to her. When she appeared to be done, he said that he was glad she came in that day. The simplicity of him just being there listening to all this horror and then genuinely communicating that he was glad to be with her spoke straight to the level of her experience where she felt utterly lonely and unlovable, cut off from everyone, unspeakably afraid and out of control in a world without allies. She cried for most of the rest of the session until John took her home. Once there, Sandy joined Julie and John to talk about what was going on. After believably agreeing not to hurt herself, they all felt it would be best to increase her shift support for at least the next week. As we had expected her to get depressed at some point and thought this was likely to be a positive development, no medication changes were indicated.

For anyone in a recovery process, waking up to who you are and how your life has been is a critical part of the recovery process. Stated succinctly by Trungpa, "Earth is good." (p.555) This dramatic shift in Julie's awareness was very sudden, which is a dangerous place for a lot of people to be. It's very difficult to tolerate how it feels to be that aware, and often people need to

diminish awareness through cultivating psychosis again, finding other ways of being defended, or by killing oneself. But Julie was able to tolerate this experience and use it as a reference point throughout the rest of her time with us. It was very striking to her that the team did not shy away from the painful intensity of her emotional state, but actually seemed to appreciate her all the more in her vulnerability and for being genuine. Julie's awakening was a dramatic example of an island of clarity, an insight that interrupts confusion and helps one to become oriented to the reality and potential sanity of here and now.

Julie's first shifts with each clinician after this breakthrough were a little awkward. She was embarrassed that people had seen her act the way she had, and was very touched that everyone stood by her. It seemed to her that we had more confidence in her than she had in herself. It appeared that she genuinely no longer wanted to die, but instead was connecting with energy and passion to be physically active and to resume her artwork.

This middle phase of treatment felt like an unleashing of her pent-up desire to have a normal life again. If that were simply a matter of her taking medications and having psychotherapy to help recover from five years of life trauma, we could have ended the team. But having been radically mood unstable for such a long time, it took Julie about a year and a half to get her moods, and the persecutory voices that came along with them, to settle. As hard as it was to be patient with this continued mood cycling, it was encouraging when she noticed that as she became more stable, the closer to a normal mood baseline she was, the more quiet and at times non-existent the voices became. Over this period of time, Julie would enthusiastically work on getting started with any number of life directions: doing art, beginning to look for work, or getting involved with organized sports. It was very difficult for her to establish continuity and momentum as frequently a hypomania would come along and reduce her ability to concentrate and tolerate people. Or she might get depressed and simply not feel like doing anything.

Despite the relentless grind of setbacks, Julie continued to get more clear about what she valued in her life and to pursue re-engaging in activities that reflected these. Volleyball and tennis, first with the team members, later with the city's Parks and Recreation leagues, became great opportunities to get her weight back down to where she felt more comfortable, to have more energy from being in shape, and to feel more like her competent self. These activities also helped her to meet new people outside the team.

A major part of the work of the team over the middle phase became helping her to learn, as John humorously put it, "the care and feeding of Julie." She essentially had to learn that how she worked with her physical world, including medications, and how she related to people, meaningful activities, and her own thinking, had a profound effect on whether her moods were more or less stable. She learned that sleep had a relationship to food, that her relationship world affected how she ate and slept, and that her thinking was related to everything. She was patient and hard working, because as tedious and frustrating as this process felt, she was feeling fundamentally inspired to know that she had a path out of her previous life predicament. She was beginning to have more of a sense of maitri toward herself, and her increasing windhorse energy was beginning to produce confidence that she was not a bad and hopeless

failure of a person. She was saying she felt better, more alive and like herself again. Life was beginning to look hopeful and workable.

As time went on, Julie was clearly becoming a peer on the team to all of us and she did not hesitate to confront us on our blind spots. For instance, she felt that for all our nice attitudes about the therapist-friend equation, she often found us to be arrogant, as psychotherapists can be, about the fact that “she” was the “client” and we were the “mature professionals” who have their lives together, and therefore, could help her with how to live hers. As uncomfortable as this was at times, we also appreciated the piercing accuracy of her observations and her confidence to speak directly to us. Our team meetings were now almost always lively, sometimes intense, as we were all not holding back as much. That shift in honesty with all of us was the outer reflection of a shift in her interest and capacity to be more honest with herself. She was gaining strength in unflinchingly identifying which of her actions and thoughts led to more confusion and suffering, and which to more health and harmony in her life. It was clear that her *allegiance to sanity* was becoming a reliable reference point, a “guiding star” for her emerging discipline.

Julie never felt compelled to be an ongoing part of the family meeting as the tension between her and her mother had seemed to resolve through their informal contacts. Between the infrequent face-to-face meetings we had with Julie and Beth present, and Beth’s more frequent phone conversations and visits, they did manage to establish a much more natural relationship tone and distance for a mother and her 29 year old daughter. This was largely possible because Julie was being “held” by the recovery environment. She was healthier, and Beth was not induced into so much vigilance and protection. Beth could treat her more like a mother and not a caretaker. Also, in a parallel process with Julie, Beth’s confidence in her recovery was strengthening. She was very appreciative of how the team was being helpful to Julie and could see the lessening of Julie’s dependence on the compensatory nature of the team as her health became more evident.

By the end of 18 months, the schedule had been reduced to four basic attendance shifts per week, one psychotherapy session per week, and with Donna, one meal per week and grocery shopping. Julie still attended all the regular meetings, but with fewer shifts we were able to reduce the number of basic attenders needed. This is often a bittersweet process of letting go of relationships that may have been close and important in such a difficult time of one’s life, and at the same time we all welcomed the reduction as a result of the recovery of health and Julie’s ability to be more independent from the team.

There was one more significant life development that occurred in this phase that shouldn’t have been a surprise. Once Julie was more confident in her ability to be in complex social environments outside the team, she found a local church to attend. It was a progressive Christian church that practiced meditation and centering prayer. Besides participating in many social activities and making some nice friendships, she began a daily meditation practice.

The end phase of Julie’s Windhorse treatment was brief, and it began with an argument. Her brother Bob was coming to town for a visit, and this seemed like an opportunity to have him join a family meeting. Julie really liked that idea. Her life was in a much better place. She was physically much healthier, she was more mood stable, and the voices had almost entirely disappeared. Most of the

organizing of her life that the team had done was now being done by her. She continued to work on relationships both in and out of the team in a wonderfully direct and honest way, and she had learned for the first time how to live with someone her age in relative harmony and be close with them at the same time. Once we settled into the family meeting, her brother said in a heartfelt way, how amazed he was to see her having such a good life. Julie exploded. "You think this is my life! I'm in treatment and have paid friends! Don't try to make me feel good because I've learned to tie my shoes and you've got your life so together." Bob was stunned. He was glad that Julie was doing this well and tried to express it. She accepted his apology and over the next hour and a half they were able to resolve the immediate tension between them. It was hard for Julie to hear that Bob's initial compliment came from the fact that his sense of how ill she was had diminished almost all his confidence that she would ever live a normal life again. Maybe not even survive. He had also been angry with her that her problems dominated their mother's time for years, and what little time their dad spent with them also seemed to be focused on Julie's problems. Her condition had affected him deeply. He didn't mean to be condescending, and he really got how she experienced it that way. Something that was particularly meaningful to Julie was an insight that both Beth and Bob had when she had become angry and essentially declared her vision that having half a life was not going to be settled for: "This feels like we've got our Julie back."

Very significantly, we all noticed that Julie did not experience any mood instability from this very intense emotional experience as she previously might have. She was very surprised by this and later said, "This showed me that I was ready to leave the treatment."

In the next week's team meeting, Julie announced that she was leaving the team in one month. She had been researching colleges where she could get a master's degree in physical education and had found one that she liked in a small city out of state, about an hour from where her father lived. School would be starting in nine months and she wanted to move there, get her life established, and get the application process underway. Once there she would also look around for a psychiatrist and a psychotherapist to continue the work she had done with us. She expressed appreciation for all the work we had done together, "I think you actually saved my life," but said she was tired of having training wheels and paid friends, and needed to get on with her life. "I think I've learned the 'care and feeding and thinking of Julie,' and have a good toolbox for when things come up that I need to deal with." Once she finished talking, she seemed to glow with a quiet resolve, confidence, and a bit of defiance.

To say we were surprised is an understatement. Also, we knew this was absolutely the right thing for her to do. But we were not ready to have her leave. We had a more graduated plan for the eventual team reduction and how we could continue to see her for years to come. We really liked her. We wanted to feel appreciated and valued. As is usually the case in the life of a family, artificial or not, emancipation isn't how the parents planned it. And as is usually the case with a successful treatment, recovery is almost always more intelligent than the clinician imagines and certainly not in the clinician's control. John was the first to say something, and much like once before, he said something simple, that "This sounded really right." Others expressed support. Someone else said, "What took you so long to figure this out?" from which we all got a good laugh.

The last month went quickly while we said our goodbyes and packed up the house. Julie was busy making her plans and saying goodbye to friends. Without a lot of sentimentality, she ended with us as individuals, and as part of the group, hosting a lovely going away party. Then she was gone.

### Case Summary

This case shows the compensatory recovery environment in action. Julie entered treatment in a highly disturbed state, in which she was not able to care for herself and had no sense of how to get back to meaningful and recognizable life. In a very real way, Julie's recovery began as she became part of a recovery environment that allowed her to have a life that functioned, because the environment functioned in a comprehensive and synchronized manner with her and her mother fully integrated into it. Simultaneously, the recovery environment provided specific and integrated psychological treatment that identified and disorganized life patterns and behaviors that were producing confusion, helped establish new ones based on health, and over time stabilized those new behaviors.

In the beginning we saw Julie explore whether she could trust the team. She knew that she needed to do something different or die, either literally or to herself as she knew herself. As with so many people who are in her predicament, it's easier to stop clinging to unhealthy defensive behavior patterns in a gentle environment. The middle phase began with Julie appreciating and learning to tolerate difficult, life-changing insight. She became more fearless and attentive to the islands of clarity that she had previously avoided. She was also continuing to live as an integral part of a sane environment. This was a world with good body and domestic practices, strong and healthy relationships, open communication, good rhythms that tended to support the harmony of the total environment, and adaptable intelligence and awareness. The mind experience of the environment was strong with a sense of allegiance to sanity, healthy self-love, confidence, and windhorse. By herself and in the varieties of dyadic and group Windhorse relationships, the practice of waking up to her sanity and developing confidence in her path of recovery became a compelling and lived experience, not unlike the contemplative training and life experience of the Windhorse clinicians.

As Julie grew healthier and more independent, we collaboratively reduced the structure of the environment. This reduced the compensatory effect, and she progressively lived a less protected and more normally engaged life, at a more comfortable relationship distance with her mother. With solid skills around working with her mood stability, with confidence in her health and that she was on a resilient recovery path, Julie left treatment. By then, she had internalized a treasure of healthy experience gained from being part of the recovery environment.

### Recovery

In Julie's case, recovery included an abatement of her primary destabilizing symptoms and a return to normal life at a higher level of functioning. To herself and her family, after treatment she looked like a mature and wiser version of that bright and good-hearted child they saw growing up.

For many others, recovery might not include significantly eliminating the life conditions and symptoms that produce confusion. This doesn't mean they cannot achieve a meaningful life with a path of recovery. (Trungpa, 2003) Whether the client has episodic problems or chronic difficulties that may require lifetime support, each is capable of discovering their own basic goodness, maitri, and windhorse energy. Fundamentally, the consistent themes in a person's recovery are that they develop confidence that they are basically good people and they forgive themselves for being different than what they or others originally thought they should be. They develop ever more reliable discipline and skills for working with their world, including mental health issues. And ultimately, instead of their life primarily reflecting unspeakable loneliness and out-of-control repetitive and undermining confusion, they stabilize on a path of synchronizing, to the best of their ability, the elements of their body, speech, and mind. This allows their life to reflect and be primarily organized by their basic sanity, good intentions, and intelligence.

### Conclusion

After 27 years and hundreds of treatments, much has been learned about Windhorse Therapy. We know it is a highly adaptable form of psychological treatment that can work with a wide variety of complex mental health and life problems. We create compensatory recovery environments that range in size from being quite small to being like small towns. Not everyone needs or wants this type of treatment, but for many who do, it can really work. It works for the client, it works for the family, and it works for the team itself. Those of us who have been fortunate to participate in this process find each team, in its own way, to be a health promoting and clarifying experience for our own growth, as human beings and as clinicians. A significant reason for this is the ability to raise individual and collective windhorse, which promotes staying committed, continually learning, and being confident in each person's possibility of recovery and growth, including our own.

We also know, based on our personal contemplative experience as well as from conducting treatments, that Windhorse Therapy is based on a powerful integration of elements central to the well-being of human beings. Succinctly put, Windhorse Therapy connects the fundamental health of a human being, which is naturally inclined toward recovery, with finely tuned treatments for the psychological disorders that are present, within in a highly adaptable recovery environment. This makes Windhorse Therapy particularly effective for complex and difficult to treat conditions.

Looking forward, we believe Windhorse Therapy has tremendous potential to evolve over time and be ever more relevant to individual and social well-being. We believe this can occur as the complementary therapies included within the recovery environments continue to advance, as new applications for the approach become apparent, and as we continue to deepen our understanding of this therapeutic process.

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